



An American plague: Pro-market believers in health policy

Comment on “On Health Policy and Management (HPAM): mind the theory-policy-practice gap”

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Abstract

Although American health policy debates address similar problems to other developed nations, it has factual and ideological specificities. I agree with Chinitz and Rodwin on the dominance of micro-economics thinking. However, I am not certain that learning from management theory or modifying medical education will be powerful enough to change the system. The vested interests of the stakeholders are too powerful, the more so when they are supported by economists who ideologically reinforce them and by neglecting the fact that the basic premises of market ideology are false when applied to medical care. There is enough empirical evidence to support that but, apparently, these facts do not dent these beliefs.

Keywords: Market Ideology, Medical Care, Microeconomic Concepts, Health Policy

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In every developed country, health policy debates address similar topics: the role of prevention, the treatment of chronic diseases, uncoordinated care, and the control of (public) costs. Those debates often, proceed as if lessons can be drawn and applied from promising national experiences abroad. In the case of the U.S., for structural as well as ideological reasons, healthcare debates are distinctive even when the topics look very similar.

World leader in medical research and technology—as well as the most diverse and innovative country for organizational innovations—the U.S. health performance is poor in many respects. Average life expectancy at birth lags behind Japan (5 years) and Western European countries (3 years). Medical (not health) expenditures are the highest in the world (over 17% of GNP or about 830 billion dollars), with an impressive gap between the U.S. and the next two highest spenders Netherlands and France, both about 12% of GNP. It is in this respect that it is fair to claim that the overall effectiveness of the U.S. system is poor. There is nothing new in this succinct description; it has broadly applied to the last 40 years, during which the high rate of medical inflation in the U.S. became one of its most salient features.

Chinitz and Rodwin (1) offer four reasons for the failure of current ideas and models to effectively reform healthcare in the U.S.: “1) the dominance of microeconomic thinking in health policy analysis and design; 2) the lack of learning from management theory and comparative case studies; 3) the separation of HPAM from the rank and file of healthcare; and 4) the failure to expose medical students to issues of HPAM”. Indeed these are part of the explanation for why, over and over again, the same debates take place, the same beliefs diffuse and the same types of research projects are, by cross-

national standards, amply financed. The first reason is indeed convincing, the second and the third are fair hypotheses, but not the last ones. Moreover, the article’s interesting analysis does not explain what could or should be done to reverse the great stability if not inertia of this American system. And I believe this conclusion holds even after taking into account Obamacare.

As Marcel Proust said: “*facts don’t enter the world of our beliefs*”. Chinitz and Rodwin (1) accurately observe that “health policy returns cyclically to financial incentives” despite the lack of evidence of the effectiveness of such incentives. Pay for performance is a mechanism to remunerate doctors for what they should do anyway. Co-payment, at best, delays the first visit to a doctor, but most patients are not good judges of what should be done for their health. Most people will get to a doctor if there is substantial suffering. But pain is not an accurate sign for the severity of a disease and if one waits too long because of a high co-payment, it can also be too late. When, after a first visit, the patient enters the medical industrial complex, he or she has little or no control of what is prescribed and co-payments do not “moderate” ensuing expenditures. Pushing the argument to its extreme, as Archibald Cochrane stated: “*you don’t prevent people from dying by increasing the price of coffins*”. To put it more mildly, when there is a question of life and death, patients and families will be disposed to sell whatever they have or borrow as much as they can to pay for costly treatment. This happens in much poorer countries in Africa or Asia, but it arises even in America. A person who might die tomorrow of a curable disease has an infinite discount rate and is indeed ready to spend whatever he has!

Medical systems with completely free access at the point of

service – as in the British National Health System or Canada's Medicare – are much cheaper than the American or the French arrangements where insured face high or moderate co-payments. This again is not new: Jost (2) and Marmor (3), among others, underlined that there is no empirical evidence to “the contention that regulated competition among health insurers restrains inflation through consumer pressures”. Not only does so-called “consumer-driven-managed-competition” increase administrative costs for the insurance companies by at least 10% of their total revenue¹, but also those companies have shown little or no interest to pressure health professions, hospitals or the pharmaceutical industry to reduce costs as long as clients can and do pay. The dominant interest of insurance firms is annual profit and market share—the more expensive healthcare, the better. And finally, co-payment is fiscally regressive, harming poor and chronically ill patients more than the financially and medically better off. It is both unfair and inefficient but still promoted by prominent figures in the political class and the media in America (and in other nations)!

Chinitz and Rodwin (1), after Kenneth Arrow, also remind us of the importance of information asymmetry in health and medical care, which is still a major problem in health policy. I do not think, however, that the solution they suggest will help much in reducing that asymmetry, with or without financial incentives. Health Information Technology (HIT) contributes to the sharing of information between health professionals and facilitates their coordination. It does not inform the patient or increase his capacity enough to judge if the care he received were appropriate. There has, to be sure, been a reduction of information asymmetry for patients with chronic diseases through the efforts of health professionals and patient's associations. General practitioners play a key role in the system as they control medical prescriptions and treatments on behalf of their patients. Therefore, the issues are more about access to Internet sites and control of prescription and not so much electronic medical records.

My final comments turn to microeconomics concepts and tools in health policy: I believe that the authors are too kind in their perspective. I would argue that it is a professional error for any social scientist to hypothesize that an actor, even when a patient, could be “irrational”. Without the hypothesis of rationality, there are no social sciences. So, when an economist assumes that a patient is not rational, he should rather look at his discipline's hypotheses that manufacture distorted lenses. As far as the “lack of comparative studies of healthcare organizations”, I agree with Chinitz and Rodwin that we need more rigorous research beyond sporadic case studies. Having spent a major part of my professional life on that topic, I believe the concepts used in most of the comparative work are poorly defined and limited in scope, as Rose and Mackenzie (4) underlined: “*it is necessary to define concepts before engaging in comparisons*”. The major problem is thus conceptual rather than methodological, even if a good methodology is a necessary condition for cross-national comparative analysis. With Sicotte (5) and Guisset *et al.* (6), I also believe that, if any, the Parsonian model of social action is more appropriate than most models currently and commonly used. A hospital, for example, is a complex organization that has to pursue broad (and often not precisely defined) goals,

acquire resources, get the support of the community as well as its employees, be compatible with existing social norms, innovate, organize the division of labor, define mechanisms of coordination (values, rules, information systems), as well as standards of quality of care it produces. Medical institutions are thus multidimensional and, again, not comprehensible by a limited rational/goal model that focuses only on financial and economic indicators. Porter and Lee (7) amuse me when they claim that market conditions will achieve the “clear goals of value for patients”. Obviously they have not spent a good part of their life in hospitals. What is “clear” when death is around the corner? What do patients value besides a reduction of their suffering, hopefully being cured and survive? Values, attitudes, power, culture, and the social norms of both patients and the medical professionals play intricate roles. Nurses and doctors try to cure and sometimes they succeed, but most of the time they just provide the care they have been taught, and that is what is expected. What is the “clear” value of a smile or a thoughtful gesture? Utilitarian reductionism is not only limited in scope but also morally unbearable. Even in France, a very centralized country with a single recruitment system for public hospitals administrators, there are important cultural nuances that reflect in the style of hospital management between the North, with a predominant legal-rational style of operation mode and the political South, which is more sensitive to the influence of lobbies.

There are always several intertwined levels and dimensions of management; the economic dimension of the production of care is just one of them. Besides that, what is important is often hidden. In 1978 Italy reformed its health system by largely copying what it took to be the British National Health Service. But, in doing so, the Italians forgot that they were not British! Among many other indicators, the operational management of a waiting list does not reflect the same rigor in different countries. As Theodore Marmor puts it, it is difficult to learn from a system, when the actors themselves do not understand why it works the way it does.

Finally, I do not believe that adding considerations of cost and access in the training of medical professionals would change much if anything. Doctors or nurses have their own definition of “quality” and are trained to improve it, as Chinitz and Rodwin suggest. It would not do harm if managers knew more about “quality”. However, I do not expect medical schools to expand their curriculum with more training in public health—in general or in health economics in particular—for medical professionals unless the trainees want to stop practicing medicine and desire to manage it. The paradigm of medical care is dual: doctors and nurses treat their patients. They apply general knowledge to a unique case. Of course, nowadays most of that knowledge does not come from case studies, but rather from cohort and controlled experiments. Nonetheless, their unit of analysis (a specific individual) is very different from the abstract categories used in public health. Public health uses social sciences concepts² to explain medical variables. Doctors are in a profession where they are expected to treat patients whatever their age, social class, or marital status. As recent British experience shows, if there are public policy concerns about prescribing an expensive drug with low effectiveness, the constraints have to be placed at a political level, not at an individual one. Doctors treat with

what they know and what they have. Treatment costs are not their primary concern. Besides, when care is free at the point of service, there is enough international data on health expenditures to support the claim that a free system for the patient is not necessarily an expensive one for the nation.

As to public health spending, which are expenditures financed by taxes, the U.S. is not that far behind other industrialized nations. In fact, even before Obama's reform, American public expenditures on healthcare (44% of 17%= 7.48%) was very similar to Organization for Economic Co-operation and Development (OECD) average (75% of 10%= 7.50%) and total expenditures were much higher (8)!

Finally, going back to the Parsonian model of social action, I doubt that American medicine would change much if medical professionals could speak the language of hospital administrators. In my research on power and innovations in American hospitals (9), I did not find any difference in the pattern of professional behavior between hospitals CEO with a medical or a business degree. The role rather than the professional background dominated. Institutions are instruments for arbitrating different sources of legitimacy, not to promote role confusion. But since the dominant American ideology is market related, the doctors have become "suppliers" and the patients "customers". With this language, "Medicine becomes then just another business", albeit a service business. This refashioned language came itself to threaten the professional ethos of medicine. The idea of a self-regulating profession not only was held up to standards it often did not meet, but over time the notion that medical care should be treated like any other commercial enterprise has taken root (10).

Comparing the three countries separated by the same language (Britain, Canada and the U.S.) – to adapt Churchill's expression – Tuohy (11) showed the importance of the initial conditions in shaping a system. Marmor and Klein (3) illustrate also that, under certain exceptional conditions, ideas can shape the creation of powerful institutions. But, when these institutions grow they create interests that will protect their position (12) and, indeed, the vested interests of America's insurance industry, the pharmaceutical industry, the hospital industry and the medical professions are huge. They do seek—and find—economists who ideologically reinforce these interests. And there are, of course, scholars and politicians such as Ted Kennedy, who long ago showed that the basic premises of market ideology are false when applied to most medical care. But they have been unable to stimulate a serious national debate. Worse yet, the only vocal ideas again Obama's reform came from extremist (or strong?) pro-market advocates. Let us hope that one day, soon, a serious political science scholar will have, in health policy, a sufficient impact!

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

JDK is the single author of the manuscript.

Endnotes

1. Administrative costs related to the financing of healthcare is 2% in England, 5.6% in France and around 15% in the U.S. for the insurance side, but it is between 25% and 30% when one considers also the administrative side in health institutions. If, in an American hospitals with 900 beds there are 1,300 billing clerks, the equivalent in France is around 30 with also a Diagnosis-Related Group (DRG) system.
2. From demography (age, gender), sociology (level of education, social class), economics (income) social-psychology (attitude), ethology, etc.

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